



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NALINI NAIK, MD
3100 TIMMONS LANE STE 250
HOUSTON, TEXAS 77027

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-0029-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER FAILED TO PAY THIS INJURED WORKERS CLAIM AND DID NOT RESPOND TO THE REQUEST FOR RECONSIDERATION AND THE ADJUSTER NEVER RETURN THE CALL LEFT FOR STATUS"

Amount in Dispute: \$750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on September, 2011 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2010	99456-RE-W6 and 99456-RE-W7	\$750.00	\$750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of Benefits (EOB) was not provided by either party to dispute.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor alleges that the respondent did not respond to its request for reconsideration. There was no documentation found to support that the carrier responded to the provider's initial bill or request for reconsideration with an EOB. There is also no response to MFDR regarding denial of disputed services. The Division will proceed with this review per applicable fee guidelines and will make its determination with the available documentation.
2. The requestor (DD) billed \$500.00 for CPT code 99456-RE-W6 for a Division requested Extent of Injury (EXT) determination. The requestor also billed \$250.00 for CPT Code 99456-RE-W7 for a Division requested determination of whether the injury was a Direct Result of the work related incident (DIR). Review of documentation supports that the Division ordered the examinations. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examinations is \$500.00. Per 28 Texas Administrative Code §134.204(i)(2)(B) & (k), the reimbursement for the 2nd RTW/EMC examination is 50% of MAR which equals \$250.00. The combined MAR for the EXT and DIR examinations is \$750.00 which is recommended for payment.

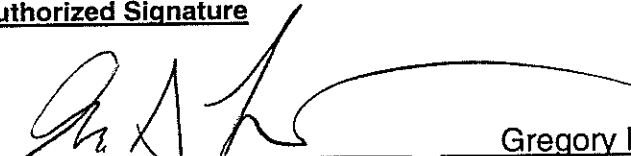
Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature


Signature

Gregory Fournerat
Medical Fee Dispute Resolution Officer

November 10, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.